

**Health Information Technology Policy Committee  
Final  
Summary of the September 14, 2010, Meeting**

**KEY TOPICS**

**1. Call to Order**

Judy Sparrow of the Office of the National Coordinator (ONC) welcomed participants to the 16<sup>th</sup> meeting of the Health Information Technology Policy Committee (HITPC). She reminded the group that this was a Federal Advisory Committee meeting, and was being conducted with the opportunity for public comment. She conducted roll call, and turned the meeting over to National Coordinator for Health Information Technology David Blumenthal, who serves as the Committee's Chair.

**2. Opening Remarks**

David Blumenthal recognized Judy Sparrow and her colleagues for their work and dedication, and for the community support that this Committee has enjoyed. The ONC and HITPC are continuing to address with fundamental issues that are important to the long-range success of their efforts but did not need to be dealt with to get to the regulatory and institutional framework of meaningful use up and running. One of fundamental issues relates to accessibility, which will be examined in depth during the next round of meaningful use work.

David Blumenthal has been traveling around the country meeting with hospital executives and state and health plan representatives to discuss and gather input on meaningful use issues. Overall success in attaining meaningful use will continue to require a great deal of work. To this end, a network of regional extension centers (RECs) and a group of state-engaged grantees have been established. In addition, community colleges are enrolling their first classes of health IT personnel for training, and there is a consumer community actively watching and participating in activities regarding consumer protection and the security of electronic health records (EHRs).

**3. Review of the Agenda**

HITPC Vice Chair Paul Tang reviewed the day's agenda and then asked for and received approval of the minutes from the last HITPC meeting (held on August 19, 2010).

**Action Item #1:** Minutes from the August 19, 2010, HITPC meeting were approved by consensus.

**4. Meaningful Use Update: Stage 2/3**

Meaningful Use Workgroup Co-Chair George Hripcsak presented a slide illustrating the timetable for meaningful use Stage 2, highlighting the following important dates/time periods:

- September 22, 2010: Meaningful Use Workgroup meeting to develop draft recommendations for Stage 2, including input/feedback from the Centers for Medicare and Medicaid Services (CMS) final rule, Meaningful Use Workgroup public hearings, the Gretzky Group report, and public input.
- October 20, 2010: Presentation to the HITPC.
- November/December 2010: Issue a Request for Information (RFI) for additional public input.
- First/Second Quarter 2011: Monitor Stage 1 submissions.
- Second Quarter 2011: Draft recommendations submitted to the HITPC.
- Late Second Quarter 2011: Final recommendations submitted to the ONC.

In Committee discussion, the following points were made related to the timeline:

- David Lansky asked if there is there any way of quantifying Stage 1 adoption rates with some type of intentional assessment. David Blumenthal commented that there is an interesting but very small survey of Chief Information Officers from the College of Health Information Management Executives, but he cautioned against making policy based on the results of intentional surveys. There will be a large amount of communication with and input from the public on this matter in the next 6 months.
- Christine Bechtel suggested that RECs and vendors are two communities that are uniquely positioned to give a sense of what is happening. She expressed interest in learning more about initial reactions such as which menu selections people are choosing and why, etc.
- Paul Eggerman expressed some concern about the timetable presented by George Hripcsak, asking how meaningful use Stage 2 would be coordinated according to this schedule with the entire certification process, given that the certification criteria for Stage 2 must be completed by April 1, 2011. The timetable will need to be accelerated, or there will need to be an understanding that it will either be raise or lower the bar—it will not allow for additional functionality beyond what is already certified. He noted that the problem lies specifically in the first and second quarters of 2011.
- Gayle Harrell explained that the Workgroup's vision had been that at stage 2, it would ramp up work and the timeline for the interoperability requirements, which would affect the certification criteria. The exchange of data should become the core of Stage 2. George Hripcsak confirmed that this was on the table for Stage 2 requirements.
- In response to a question about the needs of specialists, George Hripcsak explained that the structural measures cross the specialties, whereas the quality measures address specific specialties. The HITPC Quality Measures Workgroup will be discussing these issues.

- Richard Chapman noted that the group has been presented with a classic dilemma involving timetables that have been preset and a process that will require adjustments. In HITPC's Certification/Adoption Workgroup, members have discussed how best to obtain feedback on barriers to adoption, whether due to implementation or other factors. The Workgroup will get feedback, but all of it won't be available for Stage 2.

## 5. Quality Measures Workgroup Update

David Blumenthal reminded Committee members that a great deal of intensive work went into developing quality measures for Stage 1 meaningful use. The Notice of Proposed Rulemaking (NPRM) included more than 90 measures for eligible providers and more than 40 measures for hospitals, as well as a fair number of specialty-specific measures for eligible providers. Between 10 and 12 of the major specialty groups were addressed. One lesson learned during the process related to the extent to which quality measures were developed in a world that is heavily dependent on claims data and chart review. More broad and careful thinking is needed about the way useful, more meaningful measures in an EHR environment, including measures that may be longitudinal, can be found.

The final rule cut back on the measures, eliminating the specialty-specific measures, or at least the categorization of these measures, and cut in half the available measures for providers and hospitals. This created a challenge going forward: the lack of forethought to technical preparation should not prevent adopting a more robust and useful set of measures for Stages 2 and 3.

The ONC has put in place a new rapid turnaround effort to develop meaningful use quality measures, and the Office determined that the HITPC could make recommendations about quality measures. The Meaningful Use Workgroup did so as part of its Stage 1 work, but group was only looking at existing measures. New measures to develop and specify measures electronically, which is a much more detailed process, was not considered at that time.

A new Workgroup was needed for this effort. The new Quality Measures Workgroup was formed, and is co-chaired by David Blumenthal. This group will conduct the pioneering work of thinking about quality metrics in an electronic age. This has not been done in a systematic way in the government before, and represents an important step forward for the Department of Health and Human Services as a whole, which is now developing a national quality strategy. This new Quality Measures Workgroup will report in to this committee through the Meaningful Use workgroup.

Quality Measures Workgroup Co-Chair David Lansky then offered a presentation on the new Workgroup, to provide Committee members with a preliminary sense of where the Workgroup is moving. He presented a slide illustrating the current state of measurement:

- Stage 1 meaningful use contains 44 PRQI measures and 15 RHQDAPU clinical measures that have been retooled with electronic specifications.

- Currently, measure development does not take advantage of robust clinical health information from EHRs.
- There is a need to develop measures that are parsimonious, HIT sensitive, enable longitudinal measurement across various settings of care, improve population health, and reduce burden of care.

David Lansky shared the Workgroup's charge, objectives, measure attributes, and preliminary measure domains, and discussed methodologic issues. He noted that the Workgroup may launch some tiger teams regarding methodology problems. By the fall, the Workgroup hopes to issue an RFI to the measurement community. In December, it plans to develop a "superset" of measures, representing the outer circumference of what it plans to address. By next March, the Quality Measures Workgroup hopes to have agreement on measure priorities for Stage 2, with a final set of recommendations for what can be addressed for Stage 2 developed by May of 2011.

In discussion, the following points were made:

- Neil Calman cautioned that the Workgroup needs to be clear with regard to its activities, explaining that these are the types of measures that are established to compare different providers. Are they for internal use or for public disclosure? There are internal quality improvement measures, which allow organizations to improve their internal processes. There also are the kind of measurements that examine what kind of roles organizations play and how they are impacting their communities. Are providers capturing people longitudinally? Are they serving as agents of primary and preventive care? Neil Calman noted that the answers lead to different types of concerns and suggested that the Workgroup focus in the broadest possible way on population health, rather than using its recommendations in a way that would lead consumers to compare one provider with another.
- Gayle Harrell asked whether the HITPC has the statutory authority to carry out this work, and whether the Committee and the Quality Measures Workgroup possess the kind of experience to do this work that already exists in the community.
- Judy Murphy voiced concern that the government is getting into the EHR design business.
- David Lansky explained that the Workgroup represents an avenue to make use of public funds to create an incentive for change. Part of the Committee's statutory charge is to enable quality measurement that is meaningful, and so the HITPC needs to drive the creation of measures that matter. He expressed hope that the group finds a way to work with the vendor community to make the process as efficient as possible.
- Paul Tang suggested that the Workgroup keep to the current meaningful use domains for ease and consistency. Also, with regard to the RFI timeline, he asked if there was a way to move the May endpoint to April or earlier, to be consistent with the April timeline for meaningful use.

- Michael Klag commented it is clear that if the Workgroup focuses on measures for institutional quality improvement, once those data are available, they will be compared across institutions. He agrees that the focus should be on institutional improvement, but the HITPC has to realize that these data, though imperfect, might be compared in that way.
- David Blumenthal noted that the value and requirement for this groups' involvement stems from the fact that \$27 billion are flowing from the federal government to providers. This opportunity to disseminate and put into use the measures is almost unparalleled in terms of the meaningful use framework.

## 6. Governance Workgroup Update

Governance Workgroup Chair John Lumpkin explained to that the Health Information Technology for Economic and Clinical Health (HITECH) Act calls for the creation of a governance mechanism for the National Health Information Network (NHIN). He noted that the NHIN name is going to change in the future.

He shared the Governance Workgroup's purpose and charge. The Workgroup's overarching concerns are: (1) a governance system that engenders trust in provider, patient, and those who are exchanging data; and (2) interoperability (the group wants exchange to occur, so the appropriate information is available at the right time to enable decisions to be made between patients and caregivers).

The Governance Workgroup is responsible for the following deliverables: (1) a governance hearing on September 28, 2010; (2) initial recommendations presented to the HITPC on October 20, 2010; (3) final recommendations presented to the HITPC on November 19, 2010; and (4) a hearing and comments on the NPRM during the second or third quarter of 2011. John Lumpkin presented the Workgroup's timeline and discussed the agenda for the September 28 hearing.

In discussion, the following points were made:

- Gayle Harrell asked whether, the term "governance" in these discussions refers to oversight of the NHIN or to establishing parameters for state entities. She also asked if the HITPC has the authority to establish governance models for state and local entities. John Lumpkin explained that the Committee is examining these issues and scoping its work down in areas in which there is clearly authority for the ONC to play a role. The ONC is aiming to create an environment in which it creates the fewest barriers to exchange, while at the same time making it possible, for example, for someone in California to be comfortable exchanging with someone in Maine.
- David Blumenthal explained that there are many ways in which the ONC and the federal government can incent states and other entities to participate. This be a matter of collaborative participation as much as a coercive effort. The ONC also has the authority to create governance for NHIN. Currently, there are a dozen or so organizations, including most major federal health care entities that are participating in NHIN capabilities. They very much want guidance on how they should govern themselves. Another set of organizations,

including states, wants to join them because they realize that being able to exchange information between states is valuable for their citizens.

- Paul Eggerman noted that the NHIN is a collection of standards, and asked about the penalties for those who do not “play by the rules.” Gayle Harrell also asked about enforcement capabilities. Deven McGraw commented that this is an issue of consent, of things that are voluntarily ascribed to, for which the penalty is not being able to participate. How meaningful that is depends on the level of public acceptance of this infrastructure.
- Gayle Harrell cautioned that the ONC must make sure there are protection mechanisms available. There must be penalties involved that would make it difficult for those people who do not “play by the rules,” and it must be determined who has the authority to mete out punishment for violations.
- David Lansky said that it would be useful to develop a table or some type of framework that indicates which activities would need to be governed at which level of jurisdiction, and at what level of formality.

## **7. Information Exchange Workgroup Update**

Information Exchange Workgroup Co-Chair David Lansky reminded the group that at its last meeting, this Committee approved a refocusing of the Workgroup. Since then, the Information Exchange Workgroup has launched a Provider Directory Task Force and a Public Health Task Force as a result of feedback from the states. They have formed a provider directory task force and a public health task force.

With regard to provider directories, many state cooperative agreements are trying to stand up some type of directory function within the next few months, and so the Provider Directory Task Force’s work is urgently needed. There is a business case to be addressed. After the initial ONC funding, provider directories will need a business model to sustain whatever core model their state decides to stand up. The Workgroup is planning a hearing to discuss these issues.

The work on public health will revolve around meaningful use Stage 1 requirements relating to public health (e.g., immunization reporting, syndromic surveillance, and reportable conditions). The question is, what policy actions can be taken to get health facilities to meet the demand for public health reporting, even if there may initially be nobody on the other end to receive the information?

The Committee’s discussion included the following points:

- With regard to the provider directory requirements, Paul Tang asked about who will adopt, administer, and enforce the requirements that this group creates. If these are turned back to the NHIN Governance Workgroup, will they have to vet and endorse them? In its recommendations, the Workgroup’s goal is to articulate some high-level principles that would allow state governments to offer guidelines for best practices.



- Paul Eggerman noted that the goal is to be agnostic as to which model is being implemented. The way he hopes this group can operate is to establish a set of concepts of what needs to be included in a directory. Then, the HIT Standards Committee (HITSC) would develop recommendations, for eventual inclusion in implementation standards.
- David Blumenthal noted that the grants ONC has given to states for health information exchange require these states to develop directories. The Information Exchange Workgroup's efforts will provide them with technical assistance in doing so. It is unclear whether that then becomes something ONC certifies, because certification applies currently just to EHRs. This is one of the ways in which the ONC is trying to support states and private entities in ways that will lead to greater uniformity and reduced work.
- David Blumenthal said that the incentives/disincentives for meaningful have the potential to create a business case if meaningful use also has robust exchange requirements. For big hospitals, there could be a lot of money on the table for becoming a meaningful user, and for avoiding penalties down the road. It may be worthwhile for hospitals to support a framework for information exchange in their locales. Once this is spread across all of the groups that need to participate in the exchange, the burden will not be as great for single entities.
- Paul Eggerman suggested that there is structure and authority for the ONC to use its certification authority to establish a nationwide standard for directories. An analogy for this would be registrars on the Internet. When an entity signs up for a URL, the registrar inserts them into the various directories, and that is how they make their money. He indicated that this process would not impede states' autonomy.

## 8. Accessibility Issues

Henry Claypool, Director of the Office on Disability at the Department of Health and Human Services, explained that his comments were intended to urge the Committee to adopt and promote accessibility standards around health IT, so that those with disabilities can continue working in the field and so that technologies will not have to be retrofitted for accessibility after the fact. He offered Amazon's Kindle as an example of this. The Kindle's menu was not readable by assistive technology, and because of litigation Amazon went back and addressed the issue.

David Baquis spoke from the U.S. Access Board, the independent federal agency that wrote the guidelines for the Americans With Disabilities Act (ADA). The Board has developed standards for health information technology and provides technical assistance and training on those standards. He offered a definition of "accessibility." Some think that if a patient has access to his or her health records, the records are therefore "accessible." However, his comments were not directed at the availability of the records, but rather the removal of barriers that make it difficult for some people to use the technology. For example, they may not be able to read it, or they may not be able to use the buttons. It is this end of the usability continuum that the U.S. Access Board is concerned with, and is hoping that the HITPC can provide an assurance of nondiscrimination. Accessibility is conformance with Section 508 Standards, which apply only to federal departments and agencies. They are used even outside the federal government; states

reference them, and other countries are using them. He suggested that these be folded into the next iteration of HIT standards.

David Baquis recommended that Committee members visit the Web site [ada.gov](http://ada.gov) and review the Department of Justice (DOJ) Advanced Notice of Proposed Rule Making (ANPRM). The DOJ is considering regulating Web sites under Title II and Title III of the ADA, so providers such as hospitals and others may need to make their Web sites accessible, not just because of the positive incentive of meaningful use, but because they may otherwise end up in litigation with DOJ civil rights attorneys. He then presented the following recommendations: (1) elevate accessibility criteria to high-level status, (2) reference the Section 508 Standards in the next iteration of HHS HIT Standards, (3) include accessibility in certification testing, (4) fund HIT accessibility research, (5) develop a technical assistance and training plan, (6) understand the impact of other rulemakings on HIT, and (7) reduce burden by utilizing available resources.

The Committee's discussion included these points:

- David Lansky asked Henry Claypool and David Baquis whether they had any recommendations about quality measurement strategies, methodologies, or indicators that would determine whether the deployment of health IT is helping to reduce the disparities in health care quality. David Baquis commented that there are a number of different conferences on this subject, one of them specific to measurement. He indicated that he would look into getting the Committee access to those proceedings. One such workshop is scheduled for October 2010.
- Deven McGraw asked about the incidence of disability in the population of health care providers. She said that the Committee has been focusing its work on IT solutions from a patient's point of view, and noted that Committee discussions may not have considered the context of providers with disabilities. David Baquis offered to connect her with a group that is interested in disability issues in health education that might be able to provide some information.
- In response to a question, David Baquis explained that there are many resources available for those who want to make their Web sites and public information more accessible. [Section508.gov](http://Section508.gov) is a Web site that offers free training courses. The Access Board's Web site offers free technical assistance materials, as well as training in person, via a webinar, or audio conference. There are also for-profit accessibility consultants.
- David Baquis explained that to provide accessibility, sometimes it is a direct process (e.g., to caption a video, no extra equipment is needed). But for those who use assistive technologies such as video magnification software, simply meeting the standards means that one does not have to worry about the assistive technologies that are being used.
- David Blumenthal asked, from the perspective of the non-disabled person, whether the 508 process creates any extra burden of work for the person using a product that is up to the 508 standards, or whether it is invisible to the non-disabled person? David Baquis indicated that it should not be causing problems for people who are not disabled, and in fact it often works



the other way around. When a ramp is built into a building, then it is wheelchair accessible, and it is also more convenient for baby carriages, shopping carts, bicycles, people with heart conditions, etc.

## **9. Public Comment**

- Mary McDonald from the American Federation of Teachers explained that her organization is supportive of this group's work. She asked for guidance in where the best venue would be to air the concerns of the nurses and professionals that she represents. They include concerns about inadequate staffing during the implementation and finding ways to ensure that patients are kept safe during the implementation process. The care coordination hearing showed that there are mounting frustrations about finding a place at the national level where this conversation can occur among nurses, doctors, and vendors to determine what the barriers are to adoption of health information technology. For example, nurses in a recent survey indicated that none of the physicians would take the training on how to learn the records before the system went live. So, on the day of the go-live, the nurses had a full patient load with no extra staffing. They were learning a new system, and they were teaching the doctors the system at the same time. As a result, labs were delayed, tests were delayed, results were delayed, and patient safety was not maintained at the level that it should have been.
- Tom Leary, Senior Director Federal Affairs at the Healthcare Information and Management Systems Society (HIMSS), thanked the Committee for addressing the accessibility issue. He also noted that HIMSS has had the electronic medical record adoption model for the last several years. It has started asking questions that are pertinent to the meaningful use of products, and not just whether providers have the products in their facilities. He indicated that he looks forward to sharing this information with the Committee as they gather more robust information in the coming months.
- Robin Raiford from Allscripts suggested that a few questions be added to the Census Bureau's PHIP survey, asking people whether their doctor has an EHR and whether they want to use EHRs.

## **SUMMARY OF ACTION ITEMS:**

**Action Item #1:** Minutes from the August 19, 2010, HITPC meeting were approved by consensus.